MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03826

CERTIFICATE OF DEATH

Reg. Dist. No. 195

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

T

VS. A15

1. PLACE OF DEATH: COUNTY Howard — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Elkridge, near Laurel — LENGTH OF STAY (In this place) 7 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Scaggsville Rd.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Howard
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Elkridge, Laurel
STREET ADDRESS (If rural give location) Scaggsville Rd

3. NAME OF DECEASED (Type or Print): (First) John (Middle) Archibald (Last) Campbell

4. DATE OF DEATH: (Month) April (Day) 8 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: Nov 4, 1859

9. AGE last birthday: 89 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Georgia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Campbell

14. MOTHER'S MAIDEN NAME: Elizabeth Rushing

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Margaret Fair.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

422.2 Immediate cause (a) Chronic Myocarditis — 6 yrs.

93d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: None — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): None — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 23, 19 45, to April 8, 19 49, that I last saw the deceased alive on April 8, 19 49, and that death occurred at 12:45 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Robert J. McGarvey M.D. — ADDRESS Laurel Md — DATE SIGNED 4/9/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF April 10 1949 — NAME OF CEMETERY OR CREMATORY: Emanuel — LOCATION (City, town, or county) (State): Howard Co Scaggsville Md

DATE REC'D BY LOCAL REG. 4/9/49 — REGISTRAR'S SIGNATURE: Frank Ridgley

24. FUNERAL DIRECTOR — ADDRESS: Ridgley Selby 401 Wash. ave Laurel. Md.

RECEIVED
APR 12 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03827

CERTIFICATE OF DEATH

Reg. Dist. No. 194

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Howard — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Highland
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Howard
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Highland
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) (First) Mary (Middle) Frances (Last) Hammond

4. DATE OF DEATH (Month) (Day) (Year): 4-16-49

5. SEX: Female — 6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow

8. DATE OF BIRTH: 2-16-1864

9. AGE last birthday: 85 yrs. — If under 1 year: Months / Days / Hours / Min. / If under 24 hrs.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At Home

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Annie Dyson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If year, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Joseph Myers, Highland, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a): Acute cardiac failure — Interval between onset and death: 2 days

420.0 Antecedent cause(s)

93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b): Chronic arteriosclerotic heart disease 10 yrs

(c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July, 1946, to April 15, 1949, that I last saw the deceased alive on April 15, 1949, and that death occurred at 4 05 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Charles S. Whitaker, M.D. — ADDRESS: Clarksville, Md — DATE SIGNED: 4/25/49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: 4-19-49 — NAME OF CEMETERY OR CREMATORY: Locust Chapel — LOCATION (City, town, or county) (State): Atholton, Md

DATE REC'D BY LOCAL REG. 4-26-49 — REGISTRAR'S SIGNATURE: Marie A. Whitaker

24. FUNERAL DIRECTOR — ADDRESS: F.C. Higinbothom, Ellicott City, Md.

RECEIVED
APR 26 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03828

CERTIFICATE OF DEATH

Reg. Dist. No. 19-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Howard — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Ellicott City — LENGTH OF STAY (in this place) 70 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS New Cut Road

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Howard
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Ellicott City, Md
STREET ADDRESS (If rural give location) New Cut Road

3. NAME OF DECEASED (Type or Print): (First) Adolphus (Middle) Lewis (Last) Jones
4. DATE OF DEATH: (Month) April (Day) 12 (Year) 1949

5. SEX: Male
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Jan 16 1874
9. AGE last birthday: 75 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Duram Jones
14. MOTHER'S MAIDEN NAME: Daniet Brightful

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Wm C. Brown

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Arteriosclerotic Cardiovascular Disease — Interval between onset and death: Several yrs.

422.1

Antecedent cause(s)

932

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: —
19b. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): —
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: —
(CITY OR TOWN) (COUNTY) (STATE): —
TIME OF INJURY (Month) (Day) (Year) (Hour): — m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from April 12, 1949, to April 12, 1949, that I last saw the deceased alive on April 12, 1949, and that death occurred at 5:10 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Alpha M Herbert M.D. — ADDRESS Ellicott City Md — DATE SIGNED 4-12-49

DEPUTY MEDICAL EXAMINER OF HOWARD COUNTY

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: Apr. 16 1949 — NAME OF CEMETERY OR CREMATORY: Ellsworth — LOCATION (City, town, or county) (State): Westminster, Md

DATE REC'D BY LOCAL REG.: April 13, 1949 — REGISTRAR'S SIGNATURE: John B. Loughran. Per. B. E. L.

24. FUNERAL DIRECTOR — ADDRESS: J. E. Myers Jr. Westminster, Md.

RECEIVED
APR 16 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03829

CERTIFICATE OF DEATH

Reg. Dist. No. 194

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Howard — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN rural - Glenelg
LENGTH OF STAY (In this place) 4 mos.
HOSPITAL OR INSTITUTION OR STREET ADDRESS farm of Lawton Sharp

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Howard
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN rural - Hanover
STREET ADDRESS (If rural give location) RFD #1

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Mary	Lillie	Larrimer	April	12	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year Months	Days	If under 24 hrs. Hours	Min.
female	white	married	May 22, 1875	73 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife	home	Baltimore, Md.	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Gotleib Frey	Eliza Ann Pardoe

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
no	none	Frank O. Larrimer (husband)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Congestive heart failure	2 weeks
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Mitral stenosis	60 yrs
	(c) Rheumatic fever	60 yrs
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Generalized arteriosclerosis	30 yrs

410
92 lb

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
- - - -	- - - -	Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
none	---	- - - -		

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
----			m.		- - - -

22. I hereby certify that I attended the deceased from Feb. 23, 1949, to April 12, 1949, that I last saw the deceased alive on Apr. 11, 1949, and that death occurred at 2:30 P m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Charles S. Whitaker	M.D.	Clarksville, Md.	4-12-49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
cremation	4-15-49	Loudon Park Crematory	Baltimore, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
4-12-49	Mary A. Whitaker	Wm. J. Tickner & Sons,	Balto., MD.

RECEIVED
APR 14 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03830

CERTIFICATE OF DEATH

Reg. Dist. No. 194

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Howard; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Highland; LENGTH OF STAY (in this place) 10 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Route 29

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Howard
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Highland
STREET ADDRESS (If rural, give location) Route 29

3. NAME OF DECEASED (Type or Print): (First) Stanislaus (Middle) Mitchell (Last)

4. DATE OF DEATH: (Month) 4-8-49 (Day) 10.15 A (Year) 49

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widower

8. DATE OF BIRTH: 5-8-1859

9. AGE last birthday: 89 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Lithuania

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Charles Mitchell

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No

16. SOCIAL SECURITY No.: None

17. INFORMANT: Mrs. Stanley Johnson, Highland, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Acute Cardiac failure	10 mins.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Chronic myocarditis	10 yrs.
	(c) Coronary athero arteriosclerosis	10 yrs
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Chronic bronchitis & bronchiectasis	10 yrs

422.1
93d

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): —

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY: —

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.: —

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 24, 1947, to April 8, 1949, that I last saw the deceased alive on April 8, 1949, and that death occurred at 10:15 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Charles S. Whitaker, M.D. ADDRESS Clarksville, Md. DATE SIGNED 4-9-49

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE: 4-11-49

NAME OF CEMETERY OR CREMATORY: St. Louis

LOCATION (City, town, or county) (State): Clarksville, Md

DATE REC'D BY LOCAL REG. 4-11-49

REGISTRAR'S SIGNATURE: Marie A. Whitaker

24. FUNERAL DIRECTOR: F.C. Higinbothom ADDRESS: Ellicott City, Md.

VS. A15

RECEIVED
APR 14 1949
BUREAU V. S.

838 31

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 190

1. PLACE OF DEATH:

County: Howard

City or town: Elkridge
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 46 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For oewborn infants give residence of mother)

State: Maryland County: Howard

City or town: Elkridge
(If outside city or towo limits, write RURAL und give nearest town)

Street No. 1934 Elkridge Heights
(If rurai, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Wilhelmina Maud Simering

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband ~~or wife~~: John D. Simering

7. Birth date of deceased (mo., day, yr.): June 28, 1869 6.(c) If alive, give age ..... years

8. AGE:

Years	Months	Days	If less than one day
79	9	26	..... hrs. ..... min.

9. Birthplace: Woodstock Md
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: —

FATHER
12. Name: William Cleary
13. Birthplace: Ireland

MOTHER
14. Maiden name: Isabel Bailey
15. Birthplace: Ellicott City Md.

16. Informant: Miss Isabel Simering
Address: 1934 Elkridge Heights.

17. Burial
(Buriai, cremution, or removal. Which?)
Date thereof: April 26, 1949 (month) (day) (year)

Cemetery or ~~crematory~~: London Park

Location: Baltimore, Md.

18. Funeral director: S. Lester Earp
Address: 5503 Main St. Elkridge Md.

19. April 25 1949 (Miss) E. Bird Williams Registrar
(Date rec'd by registrar) Seal

MEDICAL CERTIFICATION

20. DATE OF DEATH: Apr 23 1949, at 5 35/a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 1 1949 to Apr 23 1949 and that I last saw her alive on Apr 23 1949

Immediate cause of death	DURATION
Acute Dilatation of heart	1 hr.
Due to Myocardial Insuff.	1 mo
Due to arterial Hypertension	5 yrs
Sen arterio sclerosis	5 yrs
Other conditions —	

443
93d

(Include pregnancy within 3 months of death)

Major findings of operations —

Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or towo) (Coonty) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Elkridge Md Date signed: 4/24/49

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
APR 26 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03837

CERTIFICATE OF DEATH

Reg. Dist. No. 191

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY: Howard; STATE: MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Ellicott City Rural; LENGTH OF STAY (in this place):

HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland; COUNTY: Howard; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Ellicott City Rural; STREET ADDRESS (If rural, give location): Old Annapolis Road

3. NAME OF DECEASED (Type or Print): (First) Frankie (Middle) M (Last) Sloan

4. DATE OF DEATH: (Month) (Day) (Year) 4-8-49 19

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 3-14-1897

9. AGE last birthday: 52 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At home

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Pierre Peters

14. MOTHER'S MAIDEN NAME: Armanda Anderson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Edward Fogle, Ellicott City, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 Immediate cause (a) Coronary Thrombosis — Interval Between Onset and Death: 45 min.

932 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertensive Cardio-Vascular Disease — 10 years

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: none

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 1, 1949, to 4-8, 1949, that I last saw the deceased alive on 4-8, 1949, and that death occurred at 6 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

George E. Burgtorf M.D. Ellicott City, Md. 4-11-49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE: 4-12-49

NAME OF CEMETERY OR CREMATORY: Good Shepherd

LOCATION (City, town, or county) (State): Ellicott City Md

DATE REC'D BY LOCAL REG.: 4/11/1949

REGISTRAR'S SIGNATURE: John B. Loughran, Asst. B. E. & L.

24. FUNERAL DIRECTOR ADDRESS: F.C. Higinbothom

RECEIVED
APR 16 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03833

CERTIFICATE OF DEATH

Reg. Dist. No. 192

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH
COUNTY: Howard — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: West Friendship
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Howard
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: West Friendship
STREET ADDRESS (If rural give location):

3. NAME OF DECEASED (Type or Print): (First) Sarah (Middle) Cornelia (Last) Stiles

4. DATE OF DEATH: (Month) April (Day) 4 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow

8. DATE OF BIRTH: 9-28-1867

9. AGE last birthday: 81 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At home

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): New Jersey

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If year, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: R.C.Stiles, West Friendship,Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral hemorrhage

422.1 Antecedent cause(s)

932 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Cardio vascular disease

(c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE OF INJURY (Home, farm, factory, street, office hldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July, 1948, to Apr 4, 1949 that I last saw the deceased alive on Apr 3 1949 and that death occurred at 6.15P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

W A Barnes MD

23. BURIAL, CREMATION / REMOVAL (Specify): Burial

DATE: 4-7-49

NAME OF CEMETERY OR CREMATORY: Loudon Park

LOCATION (City, town, or county) (State): Baltimore Md

DATE REC'D BY LOCAL REG. April 6/49

REGISTRAR'S SIGNATURE: Alice R Hebb.

24. FUNERAL DIRECTOR / ADDRESS: F.C.Higinbothom,Ellicott City,Md.

RECEIVED
APR 8 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03834

CERTIFICATE OF DEATH

Reg. Dist. No. 192

1. PLACE OF DEATH: COUNTY Howard — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural Glenelg | LENGTH OF STAY (in this place): 4 Days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Vineyard Road

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Ellicott City Md — COUNTY Howard
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN:
STREET ADDRESS (If rural give location):

3. NAME OF DECEASED (Type or Print): REV. (First) BASIL (Middle) Bernard (Last) Szeliga

4. DATE OF DEATH: (Month) April (Day) 11 (Year) 1949

5. SEX: Male. | 6. COLOR OR RACE: White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): SINGLE | 8. DATE OF BIRTH: Nov. 1909 | 9. AGE last birthday: 39 yrs. | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Roman Catholic Priest | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country): BUFFALO N.Y. | 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: ADAM SZELIGA | 14. MOTHER'S MAIDEN NAME: CONSTANCE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) | 16. SOCIAL SECURITY NO.: NONE | 17. INFORMANT: REV. MARK RAWNISZ

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Coronary occlusion — 1½ hr

420.1

Antecedent cause(s)

61

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Diabetes mellitus — Several yrs.

19a. DATE OF OPERATION: None | 19b. MAJOR FINDINGS OF OPERATION: — | 20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): — | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: — | (CITY OR TOWN): — | (COUNTY): — | (STATE): —

TIME OF INJURY (Month) (Day) (Year) (Hour) m.: — | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?: —

22. I hereby certify that I attended the deceased from April 11, 1949, to April 11, 1949, that I last saw the deceased alive on at noon, 19..., and that death occurred at ...m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Alpha N. Herbert M.D. — ADDRESS: Ellicott City Md — DATE SIGNED: 4-11-49

DEPUTY MEDICAL EXAMINER OF HOWARD COUNTY

23. BURIAL, CREMATION, REMOVAL (Specify): BURIAL | DATE: 4-13-49 | NAME OF CEMETERY OR CREMATORY: ST. STANISLAUS | LOCATION (City, town, or county) (State): CHEEKTOWAGA N.Y.

DATE REC'D BY LOCAL REG.: 4/11/49 | REGISTRAR'S SIGNATURE: A. W. Hedrick | 24. FUNERAL DIRECTOR: George A. Weber — ADDRESS: 705 S. Ann st

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15